

U.S. No. 2
FORM—5-43
Rev. 5-17-39
I X68871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19050**
Registrar's No. **4238**

FILED MAY 27 1946
318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Thomas Joseph Wilke**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **518 14 8739**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 9, 1904**
(Month) (Day) (Year)

8. AGE: Years **41** Months **8** Days **29** If less than one day _____ hr. _____ min.

9. Birthplace **Milwaukee Wis.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Wilke**
13. Birthplace **N. Dakota**
(City, town, or county) (State or foreign country)
14. Maiden name **Hattie**
15. Birthplace **Wis.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Maj. Rutschow**
(b) Address **1421 Locust (Salvation Army)**

17. (a) **Burial** (b) Date thereof **5/10/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cemetery**

18. (a) Signature of funeral director **Edith E. Ambruster**
(b) Address **4234 Manchester**

19. (a) **MAY 10 1946** (b) **J. F. Bredes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1421 Locust** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **8**
year **1946** hour **7** minute **30** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
Chronic Arteriosclerosis
Due to _____

Due to **99.1**
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Patricia E. Taylor** (M. D. or other)
Address **Deputy Coroner** Date signed **5/10/46**

(Licensed Embalmer's Statement on Reverse Side)

17928
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.